Editorials

Votes and Dollars in Health Care

IN A PRESIDENTIAL ELECTION YEAR, the political and social processes that make things happen are very much in the news and attract considerable attention. The driving forces of all this activity are votes and dollars. Politicians seeking to gain or retain public office need both in considerable quantities. They seek both wherever they are to be found, in exchange for promises and commitments—real or implied—that they may or may not wish or be able to honor when they actually gain office. Such is our political system. In the private sector some dollars are diverted for what is called political action—that is, to help candidates for political office get the votes to be elected, with the hope that they will then bear in mind the sources of this support in their actions while in office.

What has all this to do with health care? The impact of both dollars and votes has actually proved to be profound. For example, in the public arena the voting power of the elderly far exceeds that of children and youth, who cannot vote at all. And what has happened? Political support for the care of the elderly is substantially greater than for the care of children and youth, especially the needy. In the private sector, where the dollar reigns supreme, health care is increasingly seen as a profitable or potentially profitable business. The profits are derived from "consumers" who are able to pay, and, conversely, there are no profits, only unwanted costs, when those who cannot pay are served.

This has led to a truly anomalous situation where the elderly, even the rich elderly, receive good health care at government expense, while needed government programs for the children and youth upon whom the future of the nation depends are being curtailed for reasons of economy. The elderly live longer at greater and greater health care expense, while evidence accumulates that the health of youth, particularly disadvantaged youth, is being eroded. And in the private sector, 30 to 40 million Americans are said to be uninsured for health care, many because they cannot afford it or are, for some reason, uninsurable. Something is very wrong.

Votes and dollars are powerful forces in a nation with political and economic systems such as ours. This is the way it is. But these systems, stripped to their essentials, are apt to be without much human compassion, and in themselves offer little incentive for looking or planning beyond the next election or the next foreseeable bottom line. Perhaps another force is needed to influence the votes and dollars that are responsible for health care. If so, this force should be a voice of compassion for human need and a voice for the long-term betterment of the human condition within the political and socioeconomic systems where we must operate. It should be a powerful voice. Physicians and the medical profession are well positioned by interest and training to fill this role. They should be addressing those who vote and those who pay—that is, patients and the public. The campaign for a smoke-free society, which seems to be making good progress, could be something of a model for what can and should be done in the interest of health and well-being in this nation.

MSMW

Physicians and Smoking Cessation

IN 1984, JESSE STEINFELD, a former Surgeon General of the United States, wrote in this journal: "Physicians as a group have the lowest incidence of cigarette smoking of any profession or occupation. They also have both the opportunity and obligation to their patients and to society to take a far more active role in eliminating our number one health problem."[1] Earlier this year, Malcolm S. M. Watts commented in the journal: "Cigarette smoking is not only in itself a bad practice, but it can also be good practice for physicians to actively encourage their patients to quit and then find ways to help them do it."[2] In this issue, Prochazka and Boyko outline practical methods that physicians can employ to assist patients to give up smoking.

Although patients are aware of the health risks of smoking, they often do not understand the relative importance of smoking as a cause of preventable death in the United States. For example, in a recent Harris survey of the ten most important things to do to protect one's health, the general public ranked not smoking tenth, behind such items as having a smoke detector in the home and obtaining adequate vitamins and minerals. In the same survey, health professionals ranked not smoking first.[3]

Cigarette smokers experience increased total mortality, compared with nonsmokers, because they are at increased risk to die of five of the six leading causes of death in the US, including coronary artery disease, malignant neoplasms, cerebrovascular disease, chronic obstructive pulmonary disease, pneumonia, and influenza.[4,5] Cigarette smoking contributes to the development of atherosclerosis and the acute ischemic and occlusive vascular events seen with coronary artery disease, sudden unexpected death, cerebrovascular disease, arteriosclerotic peripheral vascular disease, and aortic aneurysm. Cigarette smoke contains carcinogens such as polynuclear aromatic hydrocarbons and nitrosamines, which in susceptible smokers produce cancer of the lung, larynx, mouth, esophagus, bladder, kidney, pancreas, stomach, and uterine cervix. Cigarette smoke contains pulmonary irritants that lead to chronic bronchitis. Smoking also appears to create an imbalance between pulmonary proteases and their inhibitors that results in emphysema.[6]

Cigarette smoking exerts an adverse effect on the outcome of pregnancy; spontaneous abortions, stillbirths, perinatal deaths, and low-birth-weight infants are all more likely if a woman smokes during pregnancy. Smoking also appears to produce adverse long-term effects on the physical growth and intellectual skills of children born to women who smoke while pregnant.

Peptic ulcer disease is more likely to occur, less likely to heal, and more likely to cause death in smokers than in nonsmokers. Cigarette smoking increases perioperative morbidity through its adverse effects on the cardiac, pulmonary, immune, and coagulation systems. It also alters the metabolism of commonly prescribed drugs such as theophylline and β-adrenergic blockers and thus may complicate the medical management of several diseases. Other disorders are observed more frequently in smokers than in nonsmokers, such as osteoporosis, periodontal disease, tuberculosis, infertility,